| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155249 | A. BUILDING 00<br>B. WING | 01/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE | 6006 BRANDY CHASE COVE<br>FORT WAYNE, IN46815 |

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| F0000 | This visit was for the Investigation of Complaint IN00102074.<br><br>Complaint IN00102074-Substantiated. Federal/state deficiencies related to the allegations are cited at F323 and F9999.<br><br>Survey dates: January 9, 10, 11, 2012<br><br>Facility number: 000153<br>Provider number: 155249<br>AIM number: 100266910<br><br>Survey team:<br>Ann Armey, RN<br><br>Census bed type:<br>SNF/NF: 131<br>Total: 131<br><br>Census payor type:<br>Medicare: 12<br>Medicaid: 91<br>Other: 28<br>Total: 131<br><br>Sample: 3<br><br>These deficiencies reflects state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed on January 12, | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F0323 SS=D | 2012 by Bev Faulkner, RN<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on interviews and record review, the facility failed to monitor a resident and the resident's environment for hazards, after he started a fire outside in the courtyard.<br>This deficiency affected 1 of 3 residents, whose behaviors were reviewed, in a sample of 3. (Resident #B)<br><br>Findings include:<br><br>The closed clinical record of Resident #B was reviewed on 1/9/12 at 11:00 a.m., and indicated the resident was admitted to the facility on 10/7/10, with diagnoses which included but were not limited to, traumatic brain injury, mental disorder, anxiety and depressive disorder.<br>The resident was discharged to another facility on 12/27/11.<br><br>The MDS (Minimum Data Set) Assessment, dated 10/12/11, indicated the resident's cognition was intact.<br>The MDS Assessment indicated the resident was independent for transfers, ambulation, dressing, eating, hygiene and | F0323 | I. Resident #B no longer resides in the facility, thus no further corrective action could be taken for this resident.<br><br>II. All resident care plans audited to ensure appropriate monitoring is in place for residents and residents' environment for hazards.<br><br>III. Nursing Center Staff have received in-service education relative to Accident Hazards/supervision/devices, including but not limited to monitoring to identify any potential hazards to the residents or the residents' environment. An audit tool was developed to ensure that the following aspects of care are implemented and monitored: Investigation, Statements, Assessments, MD & Family Notifications, New/Revised Interventions, Care Plan/CNA Assignment Sheet Updates, and Report to ISDH. | 02/09/2012 |

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| | toileting.<br><br>On 11/6/11 at 12:25 p.m., nursing notes indicated "CNA came to this nurse stating she saw resident at the back patio holding what looked like pliers & (and) a metal can with flames coming out of it. CNA approached resident asking him to sit the can down which he did. Another CNA came & (and) put fire out c (with) fire extinguisher. Resident became irate that the fire was put out....Resident would not give up the pliers or whatever he started the fire with..." The note indicated when he was asked what he used to start the fire he indicated he had used two sticks.<br><br>On 11/6/11 at 1:35 p.m., nursing notes indicated the resident was escorted by the police to a hospital behavioral unit for evaluation.<br><br>The transfer form, dated 11/6/11, indicated "res (resident) started fire, irrational, extremely poor judgement, won't give up lighter/matches."<br><br>On 11/6/11 at 9:15 p.m., nursing notes indicated the resident returned to the facility.<br><br>On 11/8/11 (two days later) at 6:00 a.m., nursing notes indicated 1/2 of a shredded cigarette was found in a paper medicine | | This tool will be reviewed daily, on scheduled days of work, by DNS, or designee, for one month to ensure residents and their environment remain free from potential hazards. Thereafter, this tool will be reviewed weekly, ongoing, to ensure continued compliance.<br><br>IV. The ED and DNS will report to the PI committee monthly for 6 months the information related to the audits for any further recommendation and or resolutions. | |

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| | cup by the resident's television. The physician was notified and suggested a room check.<br><br>On 1/11/12 at 10:00 a.m., the Administrator indicated Resident #B's room was checked on 11/6/11 and 11/8/11 and no matches, lighters or other hazardous materials were found in the room, but the resident's clothing was not checked. The Administrator further indicated the facility was non-smoking and cigarette smoking was not permitted in the facility.<br>Finally, the Administrator indicated a care plan related to the incident was developed on 12/21/11, 45 days after the incident, when an audit revealed a care plan had not been developed after the incident.<br><br>The care plan, dated 12/21/11, indicated the resident started small fire in the courtyard. The interventions included:<br>Medications as ordered<br>Assist resident improving reasoning skills<br>Redirect resident through the use of activities<br>Offer change of environment<br>Utilize family interactions/assistance<br>Mental Health Services as needed<br>Notify MD and POA as needed<br><br>As a result, after the resident started the fire, no care plan was developed with | | | |

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| | specific interventions to prevent the resident from starting another fire, including interventions to monitor the resident and the resident's environment on an on going basis to assure he was not in possession of hazardous materials including matches or lighters.<br><br>On 12/20/11 at 6:30 a.m., nursing notes indicated at 5:00 a.m., Resident #B was not in his room, or on an adjoining unit and a search was initiated.<br>The note indicated "...Writer re-entered (Resident B's room number) et (and) felt a breeze of cold air upon entering. Writer pulled back privacy curtain and observed resident attempting to re-enter the facility through the window...."<br><br>On 1/9/12 at 9:00 a.m., the DON (Director of Nursing) indicated Resident #B used a butter knife to remove a screw that was in place to prevent the window from opening and there was no evidence the resident actually left the facility. The DON further indicated that after the incident Resident #B was placed on one-on-one supervision that continued until he was discharged from the facility on 12/27/11.<br><br>On 12/23/11 at 2:00 p.m., social service notes indicated "Writer informed that res (resident) asked to use bathroom while on | | | |

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| | one-on-one c (with) staff. After exiting, restroom smelled of smoke and staff reported ashes to be found on floor...."<br><br>A complaint/grievance form, dated 12/23/11, indicated three quarters of a pack of cigarettes was found in the resident's jacket pocket in his room but no lighter was found.<br>The note further indicated a decision was made by the interdisciplinary team not to confront the resident about the cigarette's in his room. The report also indicated a steak knife was found under the resident's mattress and the knife was given to the social services staff person.<br><br>On 1/10/12, at 1:00 p.m., the Administrator said the cigarettes were not removed from Resident #B's room because he was on one-on-one supervision and would be leaving the facility soon. She indicated the staff were to visualize the resident at all times and to check him when he was in the bathroom.<br><br>The Smoke Free Workplace Policy, provided by the Administrator, was reviewed on 1/11/12 at 10:30 a.m., and indicated "...This policy covers smoking of any tobacco products and smokeless or "spit" tobacco and applies to employees, residents and non-employee visitors... (Facility Name) has been a smoke free | | | |

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| | facility since 2003.<br>1. There will be no smoking of tobacco products within the facility at any time..."<br><br>This Federal tag relates to Complaint IN00102074.<br><br>3.1-45(a)(1)<br>3.2-45(a)(2) | | | |
| F9999 | 3.1-13 ADMINISTRATION AND MANAGEMENT<br>(g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following:<br>(1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any:<br>(C) fires;<br><br>This state rule was not met as evidenced by: | F9999 | **F 9999**<br>I. Resident #B was discharged on 12.27.11, therefore, no further corrective action could be taken for this resident.<br><br>II. All resident events of the last 60 days have been reviewed to ensure compliance with state reporting guidelines related to unusual occurrences with no other concerns noted.<br><br>III. Nursing Center Staff have received in-service education relative to event reporting systems by Kindred Risk Management Director. An audit tool was developed to ensure that the following aspects of care are implemented and monitored: Investigation, Statements, Assessments, MD & Family Notifications, New/Revised Interventions, Care | 02/09/2012 |

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| | Based on interviews and record review, the facility failed to report a fire started by a resident to the Indiana State Department of Health.<br>This deficiency affected 1 of 1 resident reviewed, who started a fire, in a sample of 3. (Resident #B)<br><br>Findings include:<br><br>The closed clinical record of Resident #B was reviewed on 1/9/12 at 11:00 a.m., and indicated the resident was admitted to the facility on 10/7/10, with diagnoses which included but were not limited to, traumatic brain injury, mental disorder, anxiety and depressive disorder.<br>The resident was discharged to another facility on 12/27/11.<br><br>The MDS (Minimum Data Set) Assessment, dated 10/12/11, indicated the resident's cognition was intact.<br>The MDS Assessment indicated the resident was independent for transfers, ambulation, dressing, eating, hygiene and toileting.<br><br>On 11/6/11 at 12:25 p.m., nursing notes indicated "CNA came to this nurse station stating she saw resident at the back patio holding what looked like pliers & (and) a metal can with flames coming out of it. | | Plan/CNA Assignment Sheet Updates, and Reported to ISDH. This tool will be reviewed daily, on scheduled days of work, by DNS, or designee, for one month to ensure residents and their environment remain free from potential hazards. Thereafter, this tool will be reviewed weekly, ongoing, to ensure continued compliance.<br><br>IV. The ED and DNS will report to the PI committee monthly for 6 months the information related to the audits for any further recommendation and or resolutions. | |

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| | CNA approached the resident asking him to sit the can down which he did. Another CNA came & (and) put fire out c (with) fire extinguisher. Resident became irate that the fire was put out....Resident would not give up the pliers or whatever he started the fire with..." The note indicated when he was asked what he used to start the fire he indicated he had used two sticks.<br>On 11/6/11 at 1:35 p.m., nursing notes indicated the resident was escorted by the police to a hospital behavioral unit for evaluation.<br>The transfer form, dated 11/6/11, indicated "res (resident) started fire, irrational, extremely poor judgement, wont give up lighter/matches."<br><br>On 1/11/12 at 10:00 a.m., the Administrator indicated Resident #B's room was checked on 11/6/11 and 11/8/11 and no matches, lighters or other hazardous materials were found but the clothing on the resident was not checked. The Administrator further indicated the incident regarding Resident #B starting a fire in the courtyard was not reported to the Indiana State Department of Health because the fire was not in the facility.<br><br>This State rule relates to Complaint IN00102074. | | | |

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| | 3.1-13(g)(1)(C) | | | |